Department of Health
Policy/Procedure

Title:	Volunteers	Number: 07.021
References:	Agreement for Voluntary Services (DOH 720-002); Volunteer Services Report Form (DOH 720-009); Employee Responsibilities with Confidential Information (DOH 17-005)	
Contact:	Human Resources Office	
Effective Date:	November 1, 2000	
Supersedes:	07.021 dated April 19, 1991	
Approved:		
	Secretary, Department of Health	

Policy Statement:

The Department of Health encourages the use of volunteers to supplement the workforce. Volunteers should be closely supervised. Each supervisor of volunteer workers is responsible for ensuring the volunteers are aware of and comply with the policies and procedures of the department. Volunteers should not be assigned responsibility for spending authority or signature authority, they should not be placed in situations where they could take actions which would expose the department to liability risks.

Procedure:

Responsibility	**Action**
Supervisor/Assistant Secretary	Explain to the volunteer all pertinent Department of Health policies and the need to maintain confidentiality of information. Explain the duties that will be assigned to the volunteer. Complete an "Agreement for Voluntary Services" form.
Volunteer	Complete “Emergency Information Form” and “Confidentiality Acknowledgement” and send to the Department of Health Human Resources Office.
Attendance Keeper	Complete a “Volunteer Services Report Form” monthly and send to payroll so that medical aid costs can be sent to Labor and Industries.

Attachments:
Agreement for Voluntary Services (DOH 720-002)
Volunteer Services Report Form (DOH 720-009)
Emergency Information Form (DOH 720-011)
Confidentiality Acknowledgement Form

AGREEMENT FOR VOLUNTARY SERVICES

Please Print or type

Name _____ Age if under 18 _____
LAST FIRST MIDDLE INITIAL

Street Address _____

City _____State _____ ZIP _____

Statement of Work -

_____

_____

_

_____

_

Volunteer Statement of Understanding

1. I understand that I am performing the work identified in the above Statement of Work as a volunteer. As a volunteer, I understand I will not receive wages or other financial compensation from the Department of Health.

2. I agree to engage only in the work described in the Statement of Work and that the Statement of Work accurately reflects work I am capable and qualified to perform.

3. I agree to read, understand and follow Department of Health policies and procedures.

4. I understand the Department of Health places extreme importance on confidentiality of information and expects me to be especially careful to follow the department policy on public disclosure.

5. I understand that should I be injured while performing authorized work I will be covered by state industrial insurance for medical benefits.

6. Except as set forth in item 5, I will assume all risks related to my services. I will waive all claims for personal injuries or damages to property against the State of Washington, the Department of Health and its officers and employees and agree to hold the State of Washington, the Department of Health and its officers and employees harmless from all claims and liabilities of whatever nature arising out of my participation in any and all aspects of Department of Health programs.

7. I understand that either I or the Department of Health may cancel this agreement at any time by notifying the other party.

_____

_
SIGNATURE OF VOLUNTEER DATE

_____

SIGNATURE OF PARENT OR GUARDIAN, IF UNDER 18 YEARS OF AGE DATE

Acceptance for the Department of Health

Work location of volunteer:_____
UNIT OFFICE DIVISION

_____

_
SIGNATURE OF SUPERVISOR DATE

_____

_
SIGNATURE OF ASSISTANT SECRETARY/DESIGNEE DATE

*Emergency Information form must be attached and completed. Originals should be sent to the Human Resources Office at mailstop 47903.
DOH 720-002 (rev.2/91)

State of Washington
Department of Health

VOLUNTEER SERVICE REPORT FORM

Name of Volunteer
_____

Division/Office/Section
_____

Hours Worked _____ From _____ To _____
MONTH DAY MONTH DAY YEAR

Coding Information

Organization Code: _____

Coding Fund: _____ _____ _____ _____ _____
FUND APPROPRIATION INDEX PROGRAM INDEX PROJECT PRORATION

Supervisor's Signature _____ Date _____

Note: This form should be completed and sent to the Department of Health Payroll Office at the close of each month.

DOH 720-009 (6/90)

State of Washington
Department of Health

EMERGENCY INFORMATION

Name _____

Home Phone _____Work Phone _____

Classification _____

Division _____

Supervisor _____

In case of Emergency Contact:

Name _____ Phone _____

Doctor's Name _____ Phone _____

Any physical condition requiring special treatment and/or medication?

All information on this form is voluntary.

DOH 720-011 (4/90)

Statement of Acknowledgment
Department of Health Confidentiality Policy and Procedures

As an employee, contractor, volunteer, or federal assignee of the Washington State Department of Health (DOH), I understand that I am responsible for maintaining the confidentiality of any data/information collected, maintained, stored, or analyzed within DOH that I may handle during the course of my employment. Release of any data/information and documents must be in accordance with public disclosure or research laws and policies or other laws and policies controlling specific data/informing. I understand that I will receive information from my supervisor on the specific data/information that is confidential and practices for handling this data/information in my program.

I have received and read the DOH confidentiality policy (17.005) and acknowledge that I understand the policy and the responsibilities delegated to me within. I recognize and respect the confidential nature of any data/information I may have access to during the course of my employment with DOH. I will not at any time, nor in any manner, either directly or indirectly divulge, disclose, release, or communicate any confidential data/information to any third party outside the scope of my position unless authorized under the above mentioned laws and policies. I recognize that maintaining confidentiality includes discussing confidential data/information outside of the workplace.

I understand that if I discuss, release, or otherwise disclose confidential data/information outside of the scope of this policy through any means, I may be subject to disciplinary action which may include termination of employment with DOH.

Employee signature: _____ Date: _____

Please print name:_____ _____

Date received by Human Resources Office_____